Request for Self-Administration of Medication
at Wheaton Academy

Student's Name: _____ **Grade: 9 10 11 12**
(Circle One)

Physician Statement: (To be completed by student's physician)
Please Note: A change in dosage requires written authorization

Name of medication: _____ Dosage: _____

Frequency: _____

Diagnosis: _____

Other medications the student is taking: _____

This student is capable of dosing and self-administering the medication(s)? ☐ Yes ☐ No

_____ _____ _____
Physician's Signature Physician's Phone Number Date

_____
Physician's Printed Name

I/we the parent/parents or legal guardian(s) of (student's name)_____, who is enrolled as a student at Wheaton Academy for the academic school year of_____, hereby expressly authorize and give my/our permission for this student to self-administer **inhaled asthma medication**, **blood glucose testing, insulin ,Glucagon, auto-injectable epinephrine and/or the above prescribed medication** as medically indicated. This authorization and permission applies to any and all on campus activities.
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I/we agree that we have consulted with the school regarding the self-administration referenced herein. I/we agree and specifically authorize school administration to provide health information about this student to school employees, if in the school's discretion there is a need for them to know this information, to provide a safer environment for the student.

I/we understand that this authorization and permission is in force and effective for this academic school year only. I/we understand that I/we will be required to sign a new form each academic school year, with a current statement from my/our child's physician. I/we also understand that the school has the right to revoke this authorization and permission at any time, after written notice of such revocation.

I/we expressly, on my/our behalf and on behalf of the above named student, waive any liability or claim for negligence against, and agree to hold harmless, Wheaton Academy and its employees, arising out of the supervision of the self-administration of inhaled asthma medication, blood glucose testing, insulin, Glucagon, auto-injectable epinephrine, and/or the above prescribed medication by this student.

_____ _____
Parent or Legal Guardian's Signature **Date**

I, the student, understand and take responsibility for this medication and will administer it only to myself.

_____ _____
Student's Signature **Date**